PRINTED: 6/28/2023 FORM APPROVED 2567-L

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395685		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 04/04/2023	
NAME OF PROVIDER OR SUPPLIER: WALLINGFORD SKILLED NURSING AND REHABILITATION CENTER			STREET ADDRESS, 115 S PROVID WALLINGFO	ENCE RO	AD		
STATE LICENS	E NUMBER: 230102						
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DEI ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT			F 0000			
LABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN.	ATURE		TITLE:	(X6) DATE:	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395685		_		04/04/2023	
WALLING REHABIL	VIDER OR SUPPLIER: EFORD SKILLED NURSIN ITATION CENTER	G AND	STREET ADDRESS, 115 S PROVII WALLINGFO	DENCE RO	AD		
STATE LICENSE NUMBER: 230102 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHORES CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0000	Continued from page 1 Based on an Abbreviat three complaints, comp was determined that W Rehabilitation Center, the following requirem Subpart B, Requiremer Facilities and the 28 PA Pennsylvania Long Ten Regulations related to a survey process.	colleted on April 4, 20 callingford Nursing a was not in complianments of 42 CFR Partents for Long Term CA Code, Commonwerm Care Licensure	23, it and ce with 483, are ealth of	F 0000			

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	EY
		395685		B. WING: _		04/04/2023	
WALLING REHABILI	NAME OF PROVIDER OR SUPPLIER: WALLINGFORD SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 230102		STREET ADDRESS, 115 S PROVII WALLINGFO	DENCE RO	AD		
STATE LICENS (X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (FACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTI	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
F 0000	Continued from page 2			F 0000			
F 0582				F 0582			
SS=D							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395685		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/04/2023	
NAME OF PROVIDER OR SUPPLIER: WALLINGFORD SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 230102			STREET ADDRESS, 115 S PROVII WALLINGFO	DENCE RO	AD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0582	Continued from page 3			F 0582			
SS=D	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice				Plan of Correction		Completion Date: 05/18/2023
	§483.10(g)(17) The facility must- (i) Inform each Medicaid-eligible resident, in writing, time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offer and for which the resident may be charged, and the arm of charges for those services; and (ii) Inform each Medicaid-eligible resident when changare made to the items and services specified in §483.10(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically duthe resident's stay, of services available in the facility and the resident's stay, of services available in the facility and the resident's stay, of services available in the facility and the resident's stay, of services available in the facility and the resident's stay, of services available in the facility and the resident's stay, of services available in the facility and the resident's stay, of services available in the facility and the resident's stay, of services available in the facility and the resident's stay and the resident stay.		ing the offers amount anges 3.10(g)		1. Resident R1 was discharged from the facility and has not returned to the facility. A NOMNC was provided to the resident. 2. An audit was completed last 30 days by social services director or designee for short term care residents to confirm the facility provided a signed copy of the SNFABN and NOMNC letter for residents for prior to discontinuation of Medicare coverage 3. NHA Reeducated Social Services on the requirement of notification of SNFABN and NOMNC letters for residents prior to discontinuation of Medicare coverage.		Status: APPROVED Date: 04/18/2023
	of charges for those services, including any charges services not covered under Medicare/ Medicaid or b facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to resident the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items services that the facility offers, the facility must inform resident in writing at least 60 days prior to implement				4. Social Services/ Designee audit residents who had Med benefits discontinued to ensuthe letter was signed and conform of the SNFABN and NOMN for residents prior to discontion of Medicare coverage weekly weeks, Biweekly X 2 and Medicare to the QAPI committee for residents.	ticare are that appleted IC letter inuation y X 4 onthly X ubmitted	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

		(XI) PROVIDER/SUPPLIER/OIDENTIFICATION NUMBER		LIA (X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
395685		395685			<u>uu</u>	04/04/2023	
NAME OF PROVIDER OR SUPPLIER: WALLINGFORD SKILLED NURSING AND REHABILITATION CENTER 230102			STREET ADDRESS. 115 S PROVII WALLINGFO	DENCE RO	AD		
STATE LICENSE NUMBER: 230102 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0582 SS=D	of the change. (iii) If a resident dies or is hospitalized or is transferred a does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf or an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:		end to sthe ually ent within he	F 0582			

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			(X2) MULT	IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΞY
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	395685		B. WING: _		04/04/2023	
ITATION CENTER	IG AND	115 S PROVII	DENCE RO	AD		
	OF DEFICIENCIES (EACH DE	EICIENCV	ID	PROVIDENCE DE ANTOR CORRE	CTION (F. A.CH.	(V5)
MUST BE PRECEEDE		PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE	
Continued from page 5		F 0582				
Based on a review of fa	acility policies and					
procedures, record revi	iew, and staff intervi	lew, it				
was determined that the	e facility failed to er	sure the				
required Skilled Nursir	ng Facility Advance					
Beneficiary Notice of I	Non-Coverage and N	Notice of				
Medicare Provider Nor	n-Coverage was prov	vided to				
one of three residents r	reviewed. (Resident	1)				
Findings include:						
Advance Beneficiary Notice of Non-coverage (SNFABN)" states that this notice is given to residents aware of care that no longer meets Medicare coverage requirements and they may to pay out of pocket for the care listed. The provider must ensure that the beneficiary or the representative signs and dates the SNFABN to demonstrate that the beneficiary or their						
	PRECTION (POC) VIDER OR SUPPLIER: EFORD SKILLED NURSING ITATION CENTER E NUMBER: 230102 SUMMARY STATEMENT MUST BE PRECEED IDENTIFY Continued from page 5 Based on a review of from procedures, record review as determined that the required Skilled Nursing Beneficiary Notice of Medicare Provider Notion one of three residents in Findings include: Review of the form entradvance Beneficiary Notice of Medicare Coverage region (SNFABN)" states that residents aware of care Medicare coverage region pay out of pocket for provider must ensure the representative signs and demonstrate that the bear epresentative received.	RECTION (POC) IDENTIFICATION NUMBER 395685 VIDER OR SUPPLIER: FORD SKILLED NURSING AND ITATION CENTER E NUMBER: 230102 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION) Continued from page 5 Based on a review of facility policies and procedures, record review, and staff interviewas determined that the facility failed to errequired Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage and Medicare Provider Non-Coverage was provone of three residents reviewed. (Resident Findings include: Review of the form entitled "Skilled Nursin Advance Beneficiary Notice of Non-covera (SNFABN)" states that this notice is given residents aware of care that no longer meet Medicare coverage requirements and they be to pay out of pocket for the care listed. The provider must ensure that the beneficiary or representative signs and dates the SNFABN demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the beneficiary or their representative received the notice of possible demonstrate that the d	ASSESTING POC) IDENTIFICATION NUMBER: 395685 STREET ADDRESS, 115 S PROVID WALLINGFO ENUMBER: 230102 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 5 Based on a review of facility policies and procedures, record review, and staff interview, it was determined that the facility failed to ensure the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage and Notice of Medicare Provider Non-Coverage was provided to one of three residents reviewed. (Resident 1) Findings include: Review of the form entitled "Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)" states that this notice is given to make residents aware of care that no longer meets Medicare coverage requirements and they may have to pay out of pocket for the care listed. The provider must ensure that the beneficiary or their representative signs and dates the SNFABN to demonstrate that the beneficiary or their representative received the notice of possible out of	A BLDG: 395685 STREET ADDRESS, CITY, STATE, BYNDER OR SUPPLIER: FORD SKILLED NURSING AND (TATION CENTER BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 5 Based on a review of facility policies and procedures, record review, and staff interview, it was determined that the facility failed to ensure the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage and Notice of Medicare Provider Non-Coverage was provided to one of three residents reviewed. (Resident 1) Findings include: Review of the form entitled "Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)" states that this notice is given to make residents aware of care that no longer meets Medicare coverage requirements and they may have to pay out of pocket for the care listed. The provider must ensure that the beneficiary or their representative signs and dates the SNFABN to demonstrate that the beneficiary or their representative received the notice of possible out of	A BLDG: 00 B WING: 395685 STREET ADDRESS, CITY, STATE, ZIP CODE: 115 S PROVIDENCE ROAD WALLINGFORD, PA 19086 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 5 Based on a review of facility policies and procedures, record review, and staff interview, it was determined that the facility failed to ensure the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage and Notice of Medicare Provider Non-Coverage was provided to one of three residents reviewed. (Resident 1) Findings include: Review of the form entitled "Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)" states that this notice is given to make residents aware of care that no longer meets Medicare coverage requirements and they may have to pay out of pocket for the care listed. The provider must ensure that the beneficiary or their representative signs and dates the SNFABN to demonstrate that the beneficiary or their representative received the notice of possible out of	A BLDG: 90 O4/04/2023 A BUDDEN A BUDDE

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULT	IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΕY	
				A. BLDG: _			
		395685		B. WING: _		04/04/2023	
WALLING	VIDER OR SUPPLIER: EFORD SKILLED NURSIN ITATION CENTER	NG AND	STREET ADDRESS, 115 S PROVII WALLINGFO	DENCE RO	AD		
STATE LICENS	E NUMBER: 230102						
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0582	Continued from page 6			F 0582			
SS=D	The form "Instructions for the Notice of Medicare						
	Non-Coverage (NOM)						
	that informs the recipie	,					
	skilled nursing facility						
	contact a Quality Impre						
	to appeal) instructs tha	-					
	be delivered at least tw	•					
	Medicare covered serv	-					
	ensure that the benefic	*					
	signs and dates the NO						
	the beneficiary or their						
	notice and understands	•					
	can be disputed.	, vii vo riiii.wvioir or s	01 (1005				
	Review of Resident 1's	s clinical record reve	aled the				
	resident ended Medica						
	February 4, 2023 and b						
	, , , , , , , , , , , , , , , , , , , ,	The state of the s					
	Further review of Resi	dent 4's clinical reco	rd				
	revealed no evidence R						
	Attorney or Responsib						
	change in payment sou	-					
							1

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	XI) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395685				04/04/2023		
NAME OF PROVIDER OR SUPPLIER: WALLINGFORD SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 230102			STREET ADDRESS, 115 S PROVII WALLINGFO	DENCE RO	AD			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE		
F 0582	Continued from page 7			F 0582				
SS=D	Interview with License 4, 2023, at 2:00 p.m. counable to provide a sign and NONNC letter for discontinuation of Med 28 Pa. Code 201.18(b) 28 Pa. Code 201.18(e) Previously cited 10/24/28 Pa. Code 201.29(a)	onfirmed the facility ned copy of the SNF Resident 4 prior to the dicare coverage. (2) Management (1) Management (2017	was FABN					
F 0690 SS=D				F 0690				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	DENTIFICATION NUMBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395685				04/04/2023	
WALLING REHABII	OVIDER OR SUPPLIER: GFORD SKILLED NURS LITATION CENTER SE NUMBER: 230102	SING AND	115 S PROV	s, city, state, z IDENCE RO. ORD, PA 19	AD		
(X4) ID PREFIX TAG	SUMMARY STATEME MUST BE PRECE	ENT OF DEFICIENCIES (EACH DE EDED BY FULL REGULATORY O NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0690	Continued from page 8			F 0690			
SS=D			who is resses his nationence acce, the welling ical essary; elling r	Plan of Correction 1. Resident R2 care plan for urinary incontinence was implemented to ensure proper care and service. Resident R2 had a urinary and bow incontinence evaluation completed to reflect their current urinary incontinent status. 2. An audit was conducted by the Director of Nursing for all current residents regarding care plans and urinary and bowel incontinence assessments to ensure residents admitted, readmitted and with a change of condition receive the appropriate incontinent care. 3. Licensed Nursing staff will be		ted to ce. nd bowel npleted ry by the urrent ns and nce ents th a the . ill be	Completion Date: 05/18/2023 Status: APPROVED Date: 04/18/2023
	catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.		y tract ssible. e, based ility wel		reeducated by the Director of Nursing (DON) or designee importance of completing cato address urinary incontine urinary and bowel incontine assessments to ensure the bequality of care for the reside 4. DON or Designee will auresidents' records to confirm incontinence care plans are in and urinary and bowel incontinence.	on the are plans nee and nee est ent. dit a urinary in place,	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395685			<u>~~</u>	04/04/2023	
WALLING REHABILI	VIDER OR SUPPLIER: EFORD SKILLED NURSIN ITATION CENTER	G AND	STREET ADDRESS, 115 S PROVII WALLINGFO	DENCE RO	AD		
STATE LICENSE NUMBER: 230102 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0690	Continued from page 9			F 0690			
SS=D	This REQUIREMENT is no	ot met as evidenced by:			assessments are completed of admission, readmission, and significant changes. Audits we conducted weekly X 4 weeks. Biweekly X 2 and Monthly X Results of audits will be subtracted the QAPI committee for review.	with vill be 3, K 2. mitted to	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395685	B. WING:			04/04/2023	
WALLING REHABIL	VIDER OR SUPPLIER: SFORD SKILLED NURSIN ITATION CENTER SE NUMBER: 230102	NG AND	STREET ADDRESS, 115 S PROVII WALLINGFO	DENCE RO	AD		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0690 SS=D	Continued from page 10 Based on facility policy and procedure and clinical record review, and staff interview it was determined the facility failed to provide care and services to			F 0690			
	improve or maintain co four residents reviewed Findings Include:						
	Review of facility policy titled Continence Management, revised June 15, 2022, revealed patients will be assessed for the need for conti- management as part of the nursing assessment process. A urinary incontinence assessment a bowel incontinence assessment will be compl- upon admission or re-admission and with a ch- in condition or change in continence status. Continence status will be reviewed quarterly a of the care planning process. Review of Resident 2's diagnosis list revealed Resident 2 was admitted to the facility on Dec- 12, 2022, with a diagnosis of Cerebral Infarcts		led ontinence nent nt and/or npleted n change . ly as part				

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PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			A. BLDG: _	00	COMPLETED:	EY
	395685		D: ((1.10		04/04/2023	
ITATION CENTER	IG AND	115 S PROVII	DENCE RO	AD		
) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D			ID PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE
(paralysis). Review of Resident 2's (MDS-periodic assessed dated February 5, 2023 always incontinent of the Review of Resident 2's were no urinary and be since admission. Review of Resident 2's no care plan for incontreviews of continence status. The facility failed to primprove or maintained status. 28 Pa. Code 211.11(d)	a quarterly Minimum nent of resident needs, revealed the resident powel and bladder. I clinical record revealed the sessent compared to the care plan revealed the care or quarters status. To revealed the resident care and service the care and service the care and service the care plan. Resident 2's incontinuation of the care plan.	a Data Set ds), ent was aled there apleted there was erly ice to nence	F 0690			
28 Pa. Code 211.12(a)((e)(d)(1)(3)(5) Nursi	ng				
	VIDER OR SUPPLIER: EFORD SKILLED NURSINGTATION CENTER E NUMBER: 230102 SUMMARY STATEMENT MUST BE PRECEEDED IDENTIFY Continued from page 11 (stroke) and Hemipleg: (paralysis). Review of Resident 2's (MDS-periodic assessed dated February 5, 2023 always incontinent of but the state of the	VIDER OR SUPPLIER: FORD SKILLED NURSING AND ITATION CENTER E NUMBER: 230102 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION) Continued from page 11 (stroke) and Hemiplegia of dominate right (paralysis). Review of Resident 2's quarterly Minimum (MDS-periodic assessment of resident need dated February 5, 2023, revealed the reside always incontinent of bowel and bladder. Review of Resident 2's clinical record revewere no urinary and bowel assessment comsince admission. Review of Resident 2's care plan revealed to no care plan for incontinence care or quarter reviews of continence status. The facility failed to provide care and service improve or maintained Resident 2's incontinuation. 28 Pa. Code 211.11(d) Resident care plan	VIDER OR SUPPLIER: JOSEPH SKILLED NURSING AND STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 11 (stroke) and Hemiplegia of dominate right side (paralysis). Review of Resident 2's quarterly Minimum Data Set (MDS-periodic assessment of resident needs), dated February 5, 2023, revealed the resident was always incontinent of bowel and bladder. Review of Resident 2's clinical record revealed there were no urinary and bowel assessment completed since admission. Review of Resident 2's care plan revealed there was no care plan for incontinence care or quarterly reviews of continence status. The facility failed to provide care and service to improve or maintained Resident 2's incontinence status.	IDENTIFICATION NUMBER: 395685 STREET ADDRESS, CITY, STATE, 2 115 S PROVIDENCE RO WALLINGFORD, PA 19 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 11 F 0690 Continued from page 12's quarterly Minimum Data Set (MDS-periodic assessment of resident needs), dated February 5, 2023, revealed the resident was always incontinent of bowel and bladder. Review of Resident 2's clinical record revealed there were no urinary and bowel assessment completed since admission. Review of Resident 2's care plan revealed there was no care plan for incontinence care or quarterly reviews of continence status. The facility failed to provide care and service to improve or maintained Resident 2's incontinence status. 28 Pa. Code 211.11(d) Resident care plan	IDENTIFICATION NUMBER: 395685 STREET ADDRESS, CITY, STATE, ZIP CODE: 115 S PROVIDENCE ROAD WALLINGFORD, PA 19086 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 11 (stroke) and Hemiplegia of dominate right side (paralysis). Review of Resident 2's quarterly Minimum Data Set (MDS-periodic assessment of resident needs), dated February 5, 2023, revealed the resident was always incontinent of bowel and bladder. Review of Resident 2's clinical record revealed there were no urinary and bowel assessment completed since admission. Review of Resident 2's care plan revealed there was no care plan for incontinence care or quarterly reviews of continence status. The facility failed to provide care and service to improve or maintained Resident 2's incontinence status. 28 Pa. Code 211.11(d) Resident care plan	IDENTIFICATION NUMBER 395685 A. BLDG: 90 04/04/2023 A. BLDG: 90 90 90 B. WING: 155 PROVIDENCE ROAD WALLINGFORD, PA 19086 B. WING: 155 PROVIDENCE ROAD WALLINGFORD, PA 19086 COMPLETED 155 PROVIDENCE ROAD COMPLETED 155 PROVIDENCE ROAD COMPLETED 155 PROVIDENCE ROAD WALLINGFORD, PA 19086 COMPLETED 155 PROVIDENCE ROAD COMPLETED 155 PROVIDENCE R

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PLAN OF CORRECTION (POC) IDE		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395685		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/04/2023	
NAME OF PROVIDER OR SUPPLIER: WALLINGFORD SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 230102			STREET ADDRESS, CITY, STATE, ZIP CODE: 115 S PROVIDENCE ROAD WALLINGFORD, PA 19086				
(X4) ID PREFIX TAG	E NUMBER: 230102 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0690 SS=D	Continued from page 12 services 28 Pa. code 211.10(a)(d) Resident care policies		icies	F 0690			

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Certified End Page

WALLINGFORD SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 230102 SURVEY EXIT DATE: 04/04/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY